Culture and Mental Disorder: A Study of Attempted Suicide

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In a recent series of papers(1-3) reporting a study of attempted suicide, a number of observations were made which suggested the advisability of reexamining certain of the relationships between social factors and mental illness. In this paper[1] such reexamination will be undertaken. It will also be pointed out that attempted suicide and successful suicide are excellent focal points for the study of the relations between culture and mental disorder.

Method

Observations were made on 109 patients who were brought to a large general hospital immediately after having attempted suicide. These patients represented 90.1% of the 120 patients seen in the hospital emergency room for attempted suicide during a 5-month period. The criteria for accepting the patients, the method of obtaining data about them, and the psychiatric diagnostic criteria used have been described(1). All patients were examined by means of a standardized questionnaire which included open-ended and fixed-alternative questions. The questionnaire covered past and present medical history, a description of the suicide attempt, and a personal and social history. The personal and social history included information about the parental home, school record, work history, income, changes of residence, marital history, legal difficulties, arrests, drinking history, military service, and the nature of the patient's relationships with family members, friends, and associates. Social factors in the suicide attempt itself were investigated by means of inquiries concerning the "main reason" for the attempt, possibly disturbing events and symptoms occurring prior to the attempt,[2] and the patient's emotional reactions at the time of the suicide attempts [See questions 1 through 49 in a previous paper(1)]. Definitions and descriptions of the social factors studied and of the emotional states of the patients are presented elsewhere(3). The questionnaire, by means of a careful review of the medical and psychiatric history, permitted establishing whether each patient was psychiatrically ill and in the majority of instances what the nature of his disease was. It was then possible to make correlations between clinical diagnosis, the patient's adjustment during his life, and the social factors in the suicide attempt itself.

Results

The following findings concerning the interrelationships of social factors, psychiatric (clinical) diagnosis, and attempted suicide were made (Table I): 1. Every person who makes a suicide attempt is clinically ill(1, 3, 4). 2. Attempted suicide is an act which occurs in a variety of psychiatric diseases. (This is a confirmation of a previously well-known clinical

Table I

Number, Sex, and Diagnosis of the Persons Who Attempted Suicide

Diagnostic Group	Men No.	Women No.	Total Patients No.	Total Patients % of total sample
Manic-depressive depression	7	13	20	18%
Chronic alcoholism	14	2	16	15
Sociopathic personality	8	8	16	15
Conversion reaction	0	13	13	12
Chronic brain syndrome	4	3	7	6
Schizophrenia	3	3	6	5
Toxic psychosis	3	0	3	3
Drug addiction	2	1	3	3
Other diseases	1	3	4	4
Undiagnosed	7	14	21	19
Anxiety reaction	0	0	0	0
Clinically well	0	0	0	0
TOTAL	49	60	109	100%

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1. This paper is a revised version of a talk presented at a symposium on social psychiatry at the annual meeting of the Society for Applied Anthropology, May 31-June 2, 1957 at East Lansing, Michigan.

2. In addition to asking the patients for the "main reason" for the attempted suicide, we thought it important to ask whether certain specified events, the occurrence of which might have contributed to their suicide attempts, had occurred within 6 months of the attempts. Sixteen such factors were investigated systematically for each of the patients. [See questions 14-29 in the first paper of this series (1).] It should be emphasized that these sixteen factors were scored as present merely if they occurred, whether or not the patient stated they were important or relevant to the suicide attempt.

fact.) 3. There are five illnesses which account for 75% of all diagnosed patients who attempt suicide. These illnesses are sociopathic (psychopathic) personality; chronic alcoholism; conversion reaction (hysteria); chronic brain syndromes (chiefly senile psychosis and cerebrovascular disease); and manic-depressive psychosis, depressed phase (including involutional melancholia and psychotic depressive reaction). 4. There is one psychiatric illness, anxiety reaction (anxiety neurosis), in which suicide attempts rarely or never occur. 5. Clinically well (normal) persons rarely or never attempt suicide. 6. The five psychiatric illnesses which account for the majority of suicide attempts are sharply differentiated into two groups with regard to the importance of social factors in the suicide attempts. The first group (Group A), which includes sociopathic personality, chronic alcoholism, and conversion reaction, exhibits a high prevalence of social difficulties which are lifelong and apparently intimately related to their suicide attempts. The second group (Group B), which includes manic-depressive depression and chronic brain syndrome, shows a low prevalence of such difficulties. This distinction in the importance and frequency of social disturbances between the patients in these two groups of illnesses begins in the parental homes of these patients, continues throughout their lives, and ultimately plays a differential role in their suicide attempts (Table II). The patients in Group A came from parental homes broken by evidences of social maladjustment (divorce, separation, and jail) four times as frequently as those in Group B. The previous (lifelong) social adjustment, as evidenced by divorce, hospitalizations, and arrests, is remarkably poorer in Group A than Group B. The main reasons given by the patients for making suicide attempts were four times as frequently socially oriented (marital friction, frustration in love, poverty, family friction, legal prosecution, and excessive drinking) in Group A than in Group B.

All the patients were asked about 16 different social stresses which might have occurred six months preceding their suicide attempts. The answers to these questions confirmed the results concerning the main reason for the attempt. In Group A patients, at least one of the 16 social stresses had occurred in each patient, whereas in Group B patients, less than half had experienced such stresses. Finally, in order to assess the patient's emotional state, as contrasted with the occurrence of disturbing events, each patient was asked to describe his emotional state (feelings) at the time of the attempt. The Group A patients showed a much higher prevalence of feelings towards others, as contrasted with Group B patients who showed a much higher prevalence of feelings about themselves *only*. These data show that the patients are sharply divided into two groups by the clinical diagnoses in one of which social factors are apparently of strikingly greater importance than in the other.

Table II*

A Comparison of Patients in Group A with Those in Group B: Parental Home, Social Adjustment, and Precipitating Factors, and Emotional State Related to Suicide Attempt

	Group A† N = 45	Group B× N = 20
Broken parental homes		
Any reason (%)	69	47
Divorce, separation, jail (%)	45	11
Previous social adjustment		
Previous divorce (%)	63	5
Hospitalizations (Mean No.)	5.4	1.9
Arrests (%)	56	0
"Main reason" for suicide attempt		
Socially oriented (%)	71	18±
Possibly disturbing events within 6 months of suicide attempt		
Primarily social (%)	100	48**
Emotional state at time of suicide attempt		
Feelings about self only (%)	32	80
Feelings about self and towards others (%)	68	20

*The detailed data on which this table is based have appeared (3).
†Sociopathic personality, chronic alcoholism, and conversion reaction.
×Manic-depressive depression only. Chronic brain syndrome patients are similar but too few for statistical treatment.
±This figure becomes 35% if death of a loved one is included.
**This figure becomes 70% if death of a loved one is included.

Discussion

There are three considerations about attempted suicide which make it an excellent model system[3] for the study of the relation between society and mental disorder. First, as the data of this study have demonstrated, both psychiatric illness and social maladjustment occur with a high frequency among persons who attempt suicide. The study of the extent to which each predisposes to attempted suicide and how they are interrelated is a direct way in which to study the interplay of social factors and psychiatric illness. Second, relative to other symptoms and behavior which might be regarded as dependent on the interaction between psychiatric illness and social determinants, attempted suicide can be specifically defined and described. Third, sampling bias can be minimized by studying *every* suicide attempt brought to the emergency room of a large general hospital. By utilizing the emergency room, the sampling biases introduced by studying only patients who are referred to psychiatry or who have done enough damage to themselves to be admitted for medical reasons are minimized. Because not all attempted suicides are brought to a hospital, this still leaves an unknown amount of distortion in the sample selection. In the case of successful suicide, by studying every case so adjudged by the coroner, this sampling bias is virtually eliminated.

3. The social and psychiatric study of successful suicide is potentially an even better model system because the social and statistical data concerning successful suicide can be more completely collected and can be collected with less sampling bias than equivalent data on attempted suicide. [See, for example, reference (5).] The deficiency in such studies has been the absence of systematically collected psychiatric information about the individual patients in an unselected series of coroner's cases. There have been studies in which such information concerning individual patients has been given but these have been highly selected groups of patients who have been in a mental hospital previous to their suicides (6, 7). Our group is in the process of completing a study of all successful suicides in Greater St. Louis—134 persons—during a one-year period. In that study we have interviewed relatives, friends, physicians, and job associates and have obtained information from general and mental hospitals. By these means we are assembling both social data and psychiatric information about individual patients who constitute a consecutive series of cases.

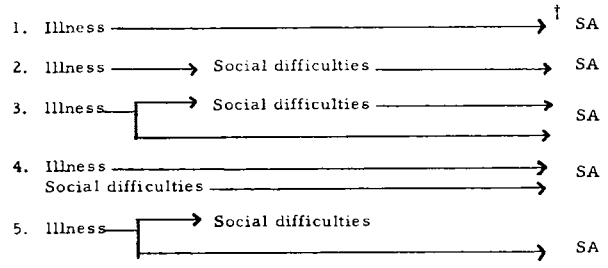
The finding that every person who attempted suicide was psychiatrically ill indicates that a) in the United States attempted suicide is not a way of responding to social stresses by clinically well persons, regardless of the severity of the stresses[4] and of the person's status in our culture, and that b) although the presence of a psychiatric illness is a necessary condition for attempting suicide it is not a sufficient condition, since not every person with a psychiatric illness which may lead to attempted suicide actually makes an attempt.

The findings that social factors were important and frequent in suicide attempts occurring in one group of psychiatric illness (sociopathic personality, chronic alcoholism, and conversion reaction) but not in another group (manic-depressive depression and chronic brain syndrome), and that the presence of a psychiatric illness is a necessary but not a sufficient condition for attempting suicide, raise the question of the precise role of social stresses in attempted suicide.

There are five possible ways in which psychiatric illness and social stresses may interact to precipitate an attempted suicide (Table III). 1. The nature of the illness is such that it directly leads to the suicide attempt without any social difficulties having been produced by the illness and without the participation of even the ordinary social difficulties experienced by human beings. 2. The illness leads to social difficulties as secondary symptoms and these difficulties autonomously precipitate the suicide attempt. The illness itself is not directly relevant to the suicide attempt but acts only by means of the social difficulties produced. In this instance, it is necessary to assume that the social difficulties produced are extraordinary (different in kind and/or degree from the social difficulties experienced by clinically well persons). This assumption is necessary since it has been shown that clinically well persons do not attempt suicide regardless of the severity of stresses they experience. 3. This is a combination of the first two possibilities. The illness produces social difficulties and these difficulties *combined* with the inherent characteristics of the disease lead to the attempted suicide. It is not necessary to postulate extraordinary social difficulties in this instance because it is assumed that the illness plays a direct role. 4. The illness does not produce social difficulties but when combined with the *ordinary* social difficulties experienced by the vast majority of human beings, a suicide attempt may be precipitated. 5. The illness produces social difficulties as symptoms but these do not operate in precipitating the suicide attempt; the attempt is directly precipitated by the nature of the illness, irrespective of the degree or kind of social difficulties produced.

Table III

Possible Interactions* between Psychiatric Illness and Social Difficulties in Precipitating a Suicide Attempt (SA)



*This study presents no data relating to the social (interpersonal and institutional) or non-social (for example, genetic) causation of psychiatric illness. The possible interactions considered are those between social difficulties and an already established psychiatric illness. It is possible that social or non-social factors may singly or in combination lead to ("cause") the illness. This possibility will not be discussed in this paper.

†The arrows may be read as "lead(s) to".

The data of this study for sociopathic personality, chronic alcoholic, and conversion reaction patients (Group A) are consistent with possibilities 2, 3, and 4 (Table III). The latter possibility is the least likely because the social difficulties which these patients experience are so extreme that it is unlikely that they could be classed as ordinary difficulties. It is not possible to choose between the other two alternatives. The question arises, however, why the suicide attempt occurred at this particular time and not at some previous or subsequent period in the person's life. The illness had been present for some years in these patients without the majority having made a suicide attempt previously. And, as far as can be ascertained from our data, there is probably nothing which distinguishes the current precipitating crises from other crises the patient had experienced previously without attempting suicide. The majority of these patients had had, prior to the crises which preceded their suicide attempts, an unusually high incidence of social stresses such as marital difficulty, divorce, frustration in love, and financial troubles. There remain at least two possibilities which cannot be eliminated: that the present stresses were quantitatively greater than the previous ones or that the illness in some fashion made the person more vulnerable to the same stresses. To test these possibilities, it would be important to do two kinds of studies: to compare a group of patients who had these illnesses and had not made a suicide attempt with a group of similar patients who had made a suicide attempt; and, to study a group of patients at the time of their suicide attempts and then to re-study the same group some years later.

The data of this study for the manic-depressive and chronic brain syndrome patients are consistent with possibilities 4, 5, and 1 (Table III). The latter possibility appears to be the least likely because manic-depressive depression does produce in some patients such social difficulties as job disability and diminished interpersonal interaction. Possibility 5 appears to be more likely than 4 because the patients infrequently report social difficulties as leading to their suicide attempts. In this connection, it is important to ask how social stresses could have been related to the suicide attempt in this group of patients. The most frequent social stress these patients report is death of a loved-one and this occurs in only 17% of the patients. Since preoccupation with death is often a symptom of manic-depressive depression, it may be that this preoccupation sensitizes these patients to the death of others. While the possibility of social stresses being important in the suicide attempt cannot be excluded in this group, it seems more reasonable for the present to consider these social stresses as of relatively little importance, since the patients report them

4. The problem of suicide in persons suffering from an incurable and painful medical disease but psychiatrically well will be considered in a future article on successful suicide.

as such and since they give no history of lifelong maladjustment. If social stresses are regarded as relatively unimportant, where else may reasons for the suicide attempt be found? Such reasons may be looked for in the nature of the illness itself. For example, a person with manic-depressive depression may feel so miserable and hopeless that he decides to commit suicide without regard for any objective or even subjective social stresses he may be undergoing. In fact, the present data have shown that social stresses, including death of a loved-one, were given as a main reason by only one-third of the manic-depressive patients, and only two-thirds of them had even a possibly disturbing social stress occurring within six months of the time of their attempted suicides.

Since social factors were found to be important in suicide attempts occurring in certain psychiatric illnesses but not in others and since no suicide attempts occurred in the absence of psychiatric illness, it becomes clear that the relation of social factors to attempted suicide is complex. Since no suicide attempts occurred in the absence of psychiatric illness, it might be assumed that the "cause" of attempted suicide was simply being psychiatrically ill, regardless of any other considerations. That this latter assumption is probably untenable is indicated by the facts that, for example, not all persons with psychiatric illnesses which are associated with attempted suicide actually attempt it, and that a group of patients with certain specific psychiatric illnesses state that social factors are related to their suicide attempts.

It can be clearly seen that, based on the data of this study, the relation of social factors to different mental illnesses cannot be described by one simple scheme. This conclusion signifies that, since there are alternative schemes which depend on the clinical diagnosis for describing the relationship of social factors to mental illness and attempted suicide, it is important to do social and clinical studies simultaneously. It seems to the present authors that there has been a greater defection on the part of psychiatrists—lack of detailed clinical studies, imprecise diagnosis—than on the part of social scientists in these collaborative efforts.

The specific psychiatric contribution to this study of attempted suicide which has proved of most value in correlating social and cultural factors and mental disorder is the clinical diagnoses of these patients. There is presently in psychiatry a marked tendency to undervalue the importance of clinical diagnosis. This appears to be a questionable practice for the following reasons: 1. There is evidence in many previous studies [see a recent tabular summary(8)] of a marked correlation between specific clinical diagnosis and many different social variables. The vast majority of these studies have been on hospitalized populations in whom the diagnosis has not been made with a research interest in mind. As a result of using hospitalized populations, the true community incidence and prevalence of the disorders as related to social variables are also not known. In spite of these deficiencies, the correlations between diagnoses and social variables are striking. 2. There is evidence for schizophrenia and manic-depressive psychosis that they are genetically distinct illnesses and that they are not different aspects or intensities of the same disease(9-13). 3. There is evidence for a number of psychiatric illnesses that one does not fade into another but that they remain as distinct entities throughout the lifetimes of the afflicted persons(14-19). Clinical diagnosis thus forms a stable, identifiable, and important aspect of behavior with which to correlate social and cultural data. As Guze(20) has pointed out, "We may go further and urge social scientists carrying out investigations . . . of psychiatric interest to deliberately plan their research to be as independent as possible of speculative psychiatric and psychologic theory." The most solidly established part of present day psychiatry is clinical diagnosis. It is not personality theory, personality description, or knowledge of the etiology of mental disease. Thus, not only is clinical diagnosis a stable and important finding in mental illness but it is also the aspect of psychiatry which depends least on presently unproven foundations.

Summary and Conclusions

1. In our culture clinically well persons rarely or never attempt suicide. Every patient in this series who attempted suicide was psychiatrically ill.

2. There is at least one psychiatric illness, anxiety reaction, in which attempted suicide occurs rarely or not at all.

3. The illnesses in which attempted suicide occurs as a symptom may be divided into two groups. In the first group, which includes sociopathic personality, chronic alcoholism, and conversion reaction (hysteria), there is a high prevalence of lifelong social difficulties which are apparently intimately related to the suicide attempt. In the second group, which includes manic-depressive depression and chronic brain syndrome, there is a low prevalence of social difficulties which show little relationship to the suicide attempt.

4. Clinical diagnosis is, therefore, an extremely important variable in determining:

a. whether or not a suicide attempt will occur,

b. whether socially oriented difficulties will be of great importance or of little importance in precipitating a suicide attempt.

5. The reported association of attempted suicide with evidences of social maladjustment is due primarily to the fact that persons with sociopathic personality, chronic alcoholism, and conversion reaction comprise approximately 50% of all persons who attempt suicide. These maladjustments do not occur with a high prevalence in the manic-depressive patients, the largest single diagnostic group of persons who attempt suicide. This suggests that these social maladjustments are not invariably important in attempted suicide.

6. The advantages of using attempted suicide, and, even more so, successful suicide, as focal points for the study of the relation of culture to mental disorder have been pointed out. The importance of having detailed clinical psychiatric information about each individual patient as well as having social and cultural data was emphasized.

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Mental Illness and the Runaway: A 30-Year Follow-Up Study

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Introduction

The effect the mental health movement has had on our attitudes toward the juvenile delinquent might be summarized as a change from the goal of Gilbert and Sullivan's *Mikado* of making "the punishment fit the crime" to the goal of making "the punishment fit the criminal." We aim not at retribution for the crime against society, but at some sort of therapy precisely tailored to the needs of the particular culprit which will so change him that he no longer desires to act in an anti-social fashion.

So ambitious a goal requires a complex fund of knowledge about the causes of anti-social behavior, if we are interested in the prevention of juvenile delinquency, and about therapies which may hope to alter established problem behavior. The years since the mental hygiene movement has brought these changes in our attitudes have seen a growing body of research into both causes of juvenile delinquency and methods of treatment. Research into the causes of delinquency has shown that poverty,[1] criminal associations,[2] separation from parents,[3] living in racially mixed and rooming house neighborhoods,[4] poor interpersonal family relations and certain personality traits[5] distinguish offenders from non-offenders and recidivist offenders from non-recidivist offenders. Research in therapy has produced less in terms of substantial correlations, probably because the follow-up studies necessary to evaluate therapy are more expensive and time-consuming than record research or retrospective evaluation of the early history of incarcerated delinquents. The few evaluations of therapy that have been attempted have been discouraging.[6]

Although the growing fund of information about juvenile delinquency is impressive, and the number of variables found to correlate with delinquency are many, there is a striking absence of research into psychiatric disease as a possible factor in the genesis of delinquency, the careers of delinquents, and their susceptibility to various therapies. There are several hints in findings available which suggest that psychiatric disease may be an important factor in delinquency. The Gluecks,[7] for instance, report differences in the Rohrschach findings in delinquent and non-delinquent boys, and also differences in personality variables as perceived in psychiatric interview.

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